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Billing and Policy
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Contents

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. The affected codes are listed below. Only those codes representing current or future Medi-Cal benefits are included. Please refer to the 2006 CPT-4 and HCPCS Level II code books for complete descriptions of these codes. Specific policy, billing information and manual replacement pages reflecting these changes will be released in a future *Medi-Cal Update.*

CPT-4 Code Additions

Anesthesia
01965, 01966

Surgery
15040, 15110, 15111, 15115, 15116, 15130, 15131, 15135, 15136, 15150, 15151, 15152, 15155 – 15157, 15170, 15171, 15175, 15176, 15300, 15301, 15320, 15321, 15330, 15331, 15335, 15336, 15340, 15341, 15360, 15361, 15365, 15366, 15420, 15421, 15430, 15431, 22010, 22015, 22523 – 22525, 28890, 32503, 32504, 33507, 33548, 33768, 33880, 33881, 33883, 33884, 33886, 33889, 33891, 33925, 33926, 36598, 37184 – 37188, 37718, 37722, 43770 – 43774, 43848, 43886 – 43888, 44180, 44186 – 44188, 44213, 44227, 45395, 45397, 45400, 45402, 45499, 45990, 46505, 46710, 46712, 50250, 50382, 50384, 50387, 50389, 50592, 51999, 53850, 57295, 58110, 61630, 61635, 61640 – 61642, 64650, 64653

Radiology
75956 – 75959, 76376, 76377, 77421 – 77423

Pathology and Laboratory
80195, 82271, 82272, 83631, 83695, 83700, 83701, 83704, 83900, 83907 – 83909, 83914, 86200, 86355, 86357, 86367, 86480, 86923, 86960, 87209, 87900, 88333, 88334, 89049

Medicine
90760 – 90768, 90779, 91022, 92626, 92627, 92630, 92633, 95865, 95866, 95873, 95874, 96101, 96116, 96118, 96401, 96402, 96409, 96411, 96413, 96415 – 96417, 96521 – 96523, 99143 – 99150, 99304 – 99310, 99324 – 99328, 99334 – 99337

HCPCS Level II Code Additions

Radiopharmaceuticals
A4641, A4642, A9500, A9502 – A9505, A9507, A9508, A9510, A9512, A9516, A9517, A9521, A9524, A9526, A9536 – A9567, A9600, A9605, A9698, A9699, C2634, C2635, C2637, Q9945 – Q9957

Surgery
C9724, C9725, S2068, S2075 – S2079, S2114, S2117

Please see **HCPCS**, *page 2*

HCPCS *(continued)*

Injections and Drugs
A9535, C9225, J0132, J0133, J0135, J0278, J0480, J0795, J0881, J0882, J0885, J0886, J1162, J1265, J1451, J1640, J1675, J1751, J1752, J1945, J2278, J2325, J2425, J2503, J2504, J2805, J2850, J3285, J7306, J9175, J9225, J9264, Q0515, Q4079, S0145

Blood Factors
J7188, J7189

Cochlear Implant Lithium Batteries
L8623, L8624

Implantable Devices and Supplies
E0616, L8680 – L8689

Ventricular Assist Devices and Supplies
Q0480 – Q0505

CPT-4 Codes with Description Changes

Surgery
15000, 15001, 15100, 15101, 15120, 15121, 15200, 15240, 15260, 15400, 15401, 16020, 16025, 16030, 30130, 30140, 30801, 30930, 31520, 31525, 31526, 31530, 31531, 31535, 31536, 31540, 31541, 31560, 31561, 31570, 31571, 33502, 34833, 34834, 37209, 44202, 44310, 44320, 45119, 45540, 45550, 50688, 52647, 52648, 57421, 64613, 67901, 67902, 69725

Radiology
75900, 76012, 77412, 78608, 78609, 78811 – 78816

Pathology and Laboratory
82270, 83036, 83630, 83898, 83901, 84238, 86022, 86023, 86920 – 86922, 87534 – 87539, 87901 – 87904, 88175

Vaccines
90713

Medicine
90657, 90658, 90870, 90940, 91020, 92506, 92507, 92520, 92568, 92569, 96405, 96406, 96420, 96422, 96423, 97024, 97811, 97813, 97814

HCPCS Level II Codes with Description Changes

Radiopharmaceuticals
A4641, A9528 – A9532

CPT-4 Code Deletions

Anesthesia
01964

Surgery
15342, 15343, 15350, 15351, 15810, 15811, 16010, 16015, 21493, 21494, 31585, 31586, 32520, 32522, 32525, 33918, 33919, 37720, 37730, 42325, 42326, 43638, 43639, 44200, 44201, 44239, 69410

Radiology
76375, 78160, 78162, 78170, 78172, 78455, 78990, 79900

Pathology and Laboratory
82273, 83715, 83716, 86064, 86379, 86585, 86587

Please see **HCPCS**, *page 3*

HCPCS *(continued)*

Medicine
90780 – 90784, 90788, 90799, 90871, 90939, 92330, 92335, 92390 – 92393, 92325, 92396, 92510, 95858, 96100, 96115, 96117, 96400, 96408, 96410, 96412, 96414, 96520, 96530, 96545, 97020, 97504, 97520, 97703, 99052, 99054, 99141, 99142, 99261 – 99263, 99271 – 99275, 99301 – 99303, 99311 – 99313, 99321 – 99323, 99331 – 99333

HCPCS Level II Code Deletions

Radiopharmaceuticals
A4643 – A4647

Implantable Devices and Supplies
E0752, E0754, E0756 – E0759

California Temporary Codes
X1520, X6112, X6210, X6836, X7030, X7493, X7660, X7662

Flow Cytometry Code Update

Effective retroactively for dates of service on or after November 1, 2005, CPT-4 code 88182 (flow cytometry, cell cycle or DNA analysis) is added as a Medi-Cal benefit.

Also effective retroactively for dates of service on or after November 1, 2005, the following flow cytometry codes have been assigned specific prices.

Codes 88184 and 88145 must be billed with modifier -TC (technical component). Codes 88187, 88188 and 88189 must be billed with modifier -26 (professional component).

The full descriptions and maximum reimbursement for the codes are:

CPT-4 Code	Description	Medi-Cal Rate
88182	Flow cytometry, cell cycle or DNA analysis	$88.27
88184	Flow cytometry cell surface, cytoplasmic, or nuclear marker, technical component only; first marker	$42.18
88185	each additional marker	$20.68
88187	Flow cytometry, interpretation; 2 to 8 markers	$55.98
88188	9 to 15 markers	$69.84
88189	16 or more markers	$92.02

No action is required on the part of providers. Claims submitted with these codes for dates of service beyond the six-month billing limit must include delay reason code "11" in the *COB (Delay Reason)* field (Box 24J) and documentation justifying the delay.

Morphometric Analysis Pricing Update

Effective retroactively for dates of service on or after November 1, 2005, CPT-4 codes 88367 and 88368 are Medi-Cal benefits. Also for the same dates of service, codes 88360, 88361, 88367 and 88368 have been assigned a specific price. No action is required on the part of providers. Claims submitted with these codes for dates of service beyond the six-month billing limit must include delay reason code "11" in the *COB (Delay Reason)* field (Box 24J) and documentation justifying the delay.

The full descriptions and prices for the codes are:

CPT-4 Code	Description	Medi-Cal Rate
88360	Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semi-quantitative, each antibody; manual	$90.06
88361	using computer-assisted technology	$136.67
88367	Morphometric analysis, in situ hybridization, (quantitative or semi-quantitative) each probe; using computer-assisted technology	$169.79
88368	manual	$120.09

Codes 88360 and 88361 cannot be billed with code 88342 (immunochemistry [including tissue immunoperoxidase], each antibody) unless each procedure is for a different antibody for the same recipient, same provider and date of service. Providers must document the different antibody in the *Reserved For Local Use* field (Box 19) or on an attachment.

Gastroesophageal Reflux Testing is New Benefit

Effective retroactively for dates of service on or after November 1, 2005, the following gastroesophageal reflux testing codes are Medi-Cal benefits.

CPT-4 Code	Description
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
91035	with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation
91038	prolonged (greater than 1 hour, up to 24 hours)
91040	Esophageal balloon distention provocation study

Codes 91034, 91035, 91037 and 91038 must be split-billed with modifier -26, -TC, -ZS or -99.

Note: Effective November 1, 2005 through July 31, 2006, providers should be retroactively reimbursed for appropriately billed claims that were denied for codes 91034 – 91040. No action is required by the provider.

A timeliness override, ending October 31, 2006, has been created for claims submitted for these services rendered for dates of service on November 1, 2005 through July 31, 2006. Providers must refer to the *HCFA 1500 Submission and Timeliness Instructions* section for specific billing procedures.

This information is reflected on manual replacement pages medne 7 (Part 2), modif used 5 (Part 2) and tar and non cd9 1 (Part 2).

Pancreas Transplant Procedures Assigned Billing Codes

Effective retroactively for dates of service on or after January 1, 2005, pancreas transplants are a Medi-Cal benefit. Billing procedures have been established for pancreas procurement, pancreas transplant and removal of transplanted pancreatic allograft.

Timeliness Policy
Timeliness policy will be overridden through October 31, 2006. Claims submitted after October 31, 2006 are subject to the standard timeliness requirements. Providers who have already billed and received payment for the service will receive a Remittance Advice Details (RAD) Code 010 denial for a duplicate claim. Re-billing must be done on a *Claims Inquiry Form* (CIF).

Contract Inpatient Provider
Inpatient providers should bill pancreas transplants using the following combination of national revenue codes and ICD-9 procedure codes:

- Revenue code 201 (intensive care, surgical) or revenue code 203 (intensive care, pediatric)
- ICD-9 procedure code 52.80 (pancreatic transplant, not otherwise specified)

A *Treatment Authorization Request* (TAR) is required for these procedures and contract providers need to have negotiated the transplant with the California Medical Assistance Commission (CMAC).

Procurement
Inpatient providers procuring a pancreas may bill for the donor pancreatectomy using CPT-4 code 48550 (donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation). Providers should bill using a separate claim and their Outpatient provider number. A TAR is required for these procedures and an invoice from an Organ Procurement Organization (OPO) must be attached to the claim.

Physician Services
Physician services for the pancreas transplant should be billed using CPT-4 code 48554 (transplantation of pancreatic allograft). A TAR is required.

Removal of Transplanted Pancreatic Allograft
Providers may bill for the removal of a transplanted pancreas with CPT-4 code 48556 (removal of a transplanted pancreatic allograft). This code requires a TAR for the primary surgeon.

The updated information is reflected on manual replacement pages transplant 5, 7 and 12 (Part 2) and tar and non cd4 5 and 6 (Part 2).

Medical Justification Required for Larger Doxorubicin HCl Dosages

Effective for dates of service on or after August 1, 2006, patients whose body surface area calculates larger than two square meters qualify for doxorubicin HCl injections above the current 40 mg limitation. Providers must document that the patient is larger than two square meters in the *Reserved For Local Use* field (Box 19) of the claim or on an attachment. Claims without justification for the additional units will be denied. Reimbursement for doxorubicin HCl injections is based on each 20 mg/m^2 unit dispensed.

Conditions that qualify patients for treatment with doxorubicin HCl are outlined in the *Chemotherapy* section in the Part 2 manual. *This information is reflected on manual replacement page chemo 24 (Part 2).*

Cochlear Implant Lithium Replacement Batteries Update

Effective retroactively to dates of service on or after November 1, 2005, HCPCS codes K0731 (lithium ion battery for use with cochlear implant device speech processor, other than ear-level, replacement, each) and K0732 (lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each) are reimbursable when used with cochlear implant devices. Codes K0731 and K0732 are subject to prior authorization. These codes do not require modifiers.

Retroactive claims with an approved *Treatment Authorization Request* (TAR) for dates of service beyond the six-month billing limit must include delay reason code "11" in the *COB (Delay Reason)* field (Box 24J) and the statement "retroactively effective to November 1, 2005." This documentation will allow the claim to process for maximum allowable reimbursement. Claims without a delay reason code and justification will be processed as late submissions and reimbursement will be reduced. Providers have 90 days to submit claims with delay reason code 11.

The updated information is reflected on manual replacement pages hcpcs ii 2 (Part 2) and surg aud 3 (Part 2).

Cancer Detection Programs: Every Woman Counts Providers May Continue to Enroll New Patients for Cervical Services

This notice affects Cancer Detection Programs: Every Woman Counts (CDP: EWC) providers with Categories of Service (COS) 115 and 072.

On May 31, 2006, the California Department of Health Services (CDHS) sent a letter to medical providers participating in CDP: EWC. The letter instructed medical providers to discontinue rendering cervical cancer screening services to all women not previously enrolled in CDP: EWC, effective June 30, 2006. This instruction also appeared in a June 2006 *Medi-Cal Update* article.

CDHS is rescinding the June 30 cutoff date stated in the letter and article. All CDP: EWC providers may continue to enroll eligible women as follows:

- COS 115 providers may enroll and provide breast and cervical cancer screening services.
- COS 072 providers may enroll and provide breast cancer screening services.
- COS 072 providers may continue to refer new CDP: EWC enrollees to COS 115 providers for cervical services.

We apologize for any confusion, concern or inconvenience the letter and article may have caused the providers and patients. The Cancer Detection Programs: Every Woman Counts program continues in full effect with no restrictions on new client enrollment.

July 1, 2006 Vision Care Cut-Off Date for Proprietary and Non-HIPAA Standard Electronic Formats Reminder

On July 1, 2006, the California Department of Health Services (CDHS) discontinued the Vision CMC proprietary claims transaction format regardless of the date services were performed. All electronically submitted vision claims must now be in the HIPAA-compliant ASC X12N 837 v.4010A1 format. To bill vision services for dates of service on or after July 1, 2006, providers have the following three options.

Paper Claims

The option to bill by paper is available for CMC providers who were unable to convert to the 837 transaction format prior to July 1, 2006. In addition, because the *Payment Request for Vision Care and Appliances* (45-1) claim form was eliminated on July 1, 2006, paper claims with dates of service on or after July 1, 2006 must be billed on the *HCFA 1500* claim form. The 45-1 must be used for claims with dates of service prior to July 1, 2006. There is also a new 50-3 *Treatment Authorization Request* (TAR) form that must be used to request prior authorization for medically necessary contact lenses and services, low vision aids and non-PIA covered eye appliances for dates of service on or after July 1, 2006.

Electronic Claim Submission Using the Internet

Providers who successfully completed the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHS 6153) and test claims may bill electronically on the HIPAA-compliant 837 transaction.

When converting to the 837 transaction, the Vision Data Specifications should be used for claims with dates of service prior to July 1, 2006. For dates of service on or after July 1, 2006, the Medical Data Specifications (part of the *837 v.4010A1 Health Care Claim Companion Guide*) has been updated to include the required segments for vision claims.

The companion guides are available on the *ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications* page of the Medi-Cal Web site.

Internet Professional Claims Submission

The HIPAA-compliant *837 Internet Professional Claim Submission (IPCS) Online Claim Form* has been updated and is available for claims with dates of service on or after July 1, 2006. The IPCS system gives vision care providers an alternate method of submitting electronic claims in real-time through the Medi-Cal Web site at **www.medi-cal.ca.gov**. Providers who successfully completed the *Medi-Cal Point of Service (POS) Network/Internet Agreement* and *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHS 6153) forms can bill using IPCS.

The IPCS system allows users to submit single vision service claims in real-time. The IPCS system does not perform online adjudication nor does it accept crossover claims. Claims submitted successfully receive a Claim Control Number (CCN) on the host response screen. If the IPCS system detects errors, the user will receive a "CLAIM REJECTED" message on the host response screen, and the claim can be edited to correct these errors before resubmitting. The IPCS system allows faster and more efficient data exchange between providers and CDHS.

Please refer to the *Internet Professional Claim Submission (IPCS) User Guide* for details on necessary forms and instructions.

Please see **HIPAA**, *page 8*

HIPAA *(continued)*

Electronic Attachments
Providers may now submit electronic 837 claims and fax their attachments. To use this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes a *Medi-Cal Claim Attachment Control Form* (ACF), used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment of the transaction. Providers submit the electronic claim and fax the ACF along with the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include one ACF as the first page followed by the attachment pages that correspond to that ACF. Additional ACFs and attachments must be sent as separate calls to the fax server. The number to fax attachments is 1-866-438-9377.

In addition to faxing them, providers may also mail hard copy attachments. Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or hard copy attachments. For information about how to send attachments, including the mailing address, providers may refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site.

Additional Resources
For more information, in-state providers may call the Telephone Service Center (TSC) at 1-800-541-5555, 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200.

Family PACT Clinical Services and Pharmacy Benefit Corrections

Family PACT (Planning, Access, Care and Treatment) providers should note the following three corrections, indicated with underlined text, to the Family PACT Clinical Services and Pharmacy Benefit article that was published in the June 2006 *Medi-Cal Update.* These three corrected statements appear in different parts of the article.

Restrictions
The following CPT-4 codes are restricted to females ages 15 to 55 years of age: 00940, 57452, 57454, 57455, 57456, 57460, 57511, 87621, 88305 and 88307.

Deletions and Replacements
Syphilis: Range 091.0 – 097.9 is replaced with 091.0, 091.3, 092.9, 096, 097.1, 616.50, 608.89 and V01.6.

Core Secondary Service: Immunization
A primary diagnosis is required for administration of Hepatitis B vaccine to non-immunized clients.

Other Secondary Services						Complications Services (10)
Vaccine	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Description**
Hepatitis B Use appropriate primary diagnosis code	Hepatitis B immunization		None	None	Hepatitis B vaccine 90743 90744 90746 Modifiers required	Allergic reaction to Hepatitis B vaccine Vaso-vagal episode

(10) Complications services for a secondary diagnosis require a primary diagnosis (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR)* section.

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The dates for upcoming sessions are listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Sessions below.

Fullerton

July 20, 2006
California State University, Fullerton
TSU Building, Pavilion A
800 N. State College Boulevard
Fullerton, CA 92813

Los Angeles

August 14, 2006
Radisson Wilshire Plaza Hotel
3515 Wilshire Boulevard
Los Angeles, CA 90010

San Diego

August 24, 2006
Manchester Grand Hyatt
One Market Place
San Diego, CA 92101

For a map and directions for these locations, go to the Family PACT Web site at **www.familypact.org** and click the appropriate session date under "Provider Orientations" and then click the "For directions: click here" link.

Registration
To register for an Orientation and Update session, go to the Family PACT Web site at **www.familypact.org,** click "Registration" next to the appropriate date under "Provider Orientations" and print a copy of the registration form. Fill out the form and fax it to the Office of Family Planning, Attn: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Please see **Family PACT**, *page 10*

Family PACT *(continued)*

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider is mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

Contact Information
For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Blood Factor Billing Code Update for Pharmacists

Effective for dates of service on or after July 1, 2006, pharmacy providers must bill Blood Factor products (formerly known as Anti-Hemophilia Factor products) using National Drug Codes (NDC) rather than HCPCS codes.

Physicians and clinicians must continue to bill using HCPCS codes currently in place.

When billing with NDCs, pharmacists will be able to bill claims electronically. However, providers who bill for California Children's Services (CCS)-only, CCS/Healthy Families, Genetically Handicapped Persons Program (GHPP)-only eligible recipients, or for Medi-Cal/CCS/GHPP-eligible recipients with a CCS or GHPP Legacy authorization, must bill hard copy due to the required authorization by the Children's Medical Services Branch. Providers can submit electronic claims when billing pursuant to a CCS *Service Authorization Request* (SAR) for CCS Medi-Cal-eligible recipients.

Medi-Cal will continue to reimburse providers the lesser of the manufacturer's Average Selling Price plus 20 percent or the provider's usual and customary charge.

The updated information is reflected on manual replacement pages blood 1 thru 4 (Part 2) and blood hcfa 2 thru 5 (Part 2).

CCS Service Code Groupings (SCG) Update

Retroactive for dates of service on or after July 1, 2004, a number of codes are added to the California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03 and 07.

In addition, code 99359 is end-dated for dates of service on or after July 1, 2006.

Reminder: SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same "rules" apply to end-dated codes.

The updated information is reflected on manual replacement pages cal child ser 5, 12 and 15 (Part 2).

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs, Drugs: Contract Drugs List Part 2 – Over-the-Counter Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs.*

Additions, effective July 1, 2006

Drug	**Size and/or Strength**
LEVALBUTEROL TARTRATE	
Oral inhaler without chlorofluorocarbons as the propellant	15 Gm

Changes, effective June 1, 2006

Drug	**Size and/or Strength**	
DESMOPRESSIN ~~ACETATE~~		
Injection	4 mcg/cc	
Nasal solution **or spray**	0.01 %	2.5 cc
		5 cc
Tablets		

Changes, effective July 1, 2006

Drug	**Size and/or Strength**
BALSALAZIDE DISODIUM	
+ Capsules	750 mg
(NDC labeler code 65649 [Salix Pharmaceutical] only.)	
CIPROFLOXACIN HCL	
***** Tablets	250 mg
	500 mg
	750 mg
* Restricted to use in the treatment of 1) lower respiratory tract infections in persons aged 50 years and older; 2) osteomyelitis; and 3) pulmonary exacerbation of cystic fibrosis.	
*** Tablets, extended release**	**500 mg**
*** Restricted to use in the treatment of urinary tract infections. Also restricted to a maximum of three (3) tablets per dispensing and a maximum of two (2) dispensings in any 30-day period.**	
Ophthalmic solution	0.3 %

\+ Frequency of billing requirement

Please see **Contract Drugs**, *page 12*

Contract Drugs *(continued)*

Changes, effective July 1, 2006 (continued)

Drug	Size and/or Strength	
* INTERFERON ALFACON-1		
Injection	30 mcg/cc	0.3 cc
		0.5 cc
Injection, prefilled syringe	30 mcg/cc	0.3 cc
		0.5 cc

*** Restricted to NDC labeler code 55513 [Amgen USA] for claims submitted with dates of service from September 1, 1998 to September 30, 2003 for the treatment of chronic hepatitis C virus infection.**

PRAVASTATIN		
+ Tablets	10 mg	90's
	20 mg	90's
	40 mg	90's
	80 mg	90's

(NDC labeler code 00003 [Brystol-Myers Squibb] only.)

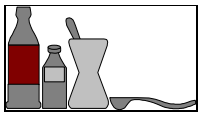
Changes, effective August 1, 2006

Drug	Size and/or Strength
***** ZOLPIDEM TARTRATE	
+ Tablets	5 mg
	10 mg
+ Tablets, extended-release	**6.25 mg**
	12.5 mg

(NDC labeler code 00024 [Sanofi-Aventis] only.)

* Restricted to use in treatment of insomnia

\+ Frequency of billing requirement



DRUG USE REVIEW
Educational Information

Rate of Hemoglobin A1C Testing in the Medi-Cal FFS Population

Glycemic control is paramount to the short-term and long-term management of diabetes. Monitoring of blood glucose via the hemoglobin A1C test and self-monitoring is the standard of care for patients with diabetes. This bulletin focuses on the A1C test and provides information about the rate of testing in the Medi-Cal fee-for-service (FFS) population.

Glucose Control and the Hemoglobin A1C Test

The results of the Diabetes Control and Complications Trial and the United Kingdom Prospective Diabetes Study demonstrate that tight control of blood glucose (with an average A1C $\leq$ 7 percent) helps reduce the rate of secondary microvascular complications such as nephropathy, neuropathy, and retinopathy[1,2].

Performing regular A1C tests allows the provider to:

- Document initial assessment of glucose control status and determine target range
- Assess average glucose levels over the past 2 to 3 months
- Detect departures from target goal and allow for timely adjustments in therapy
- Verify the patient's self-monitored glucose meter readings

Please see **Drug Use Review**, *page 13*

American Diabetes Association (ADA) Standards of Medical Care in Diabetes Monitoring Recommendations[3]:

- Perform the A1C test **twice a year** in patients that are at glycemic goal and stable metabolic status
- Perform the A1C test **every three months** in patients that are not at glycemic goal or patients that have changing therapy
- Use **point-of-care** testing of A1C to make therapy changes in a timely manner
- **The goal A1C for *most* patients is 7 percent or below**

Frequency of A1C testing may depend on the clinical situation, the treatment regimen used and the judgment of the clinician. Deviations from standard A1C goals and monitoring frequency may be appropriate for the following patients: pregnant, the young and the elderly (<13 years old and >65 years old), and those experiencing hypoglycemia.

Rate of Hemoglobin A1C Testing in the Medi-Cal FFS Beneficiary Population

A retrospective study of Medi-Cal FFS recipients with diabetes was conducted to determine if prescribers/patients are adhering to recommended ADA standards of care. Patients continuously enrolled in the Medi-Cal Fee-For-Service program between January 1, 2005 and December 21, 2005 with a diagnosis of diabetes (ICD-9 code 250.xx) who had two or more paid claims in an outpatient setting (excluding long-term and acute care settings) AND one paid claim for a diabetic medication that consisted of either a hypoglycemic agent, insulin or diabetic supplies were included in the analysis. It should be noted that this diabetic definition does not follow HEDIS measures and, therefore, results should not be used as a direct comparison. Recipients with a Medicare benefit were excluded. Claims for these recipients were analyzed to determine compliance with ADA guidelines concerning A1C testing (CPT-4 code 83036).

During the 12-month study period, 10,948 recipients with diabetes were identified:

- 76 percent had received at least one HbA1C test in 2005
- 42 percent received the ADA recommended two HbA1C tests in 2005
- 79 percent who are taking two or more drugs had an A1C test during the study period

The above results are a good start, and hopefully improvement will be made over time with an increase in HbA1C testing when new drug therapy is initiated or dosage adjustments made. Future studies in this area may expand diagnosis codes and place of service settings to measure the quality of care given to Medi-Cal recipients in long-term care and hospital settings.

Recommendations

Medi-Cal wants to ensure that the recipients utilizing diabetes medications are receiving adequate monitoring. The following steps should be followed by pharmacists and physicians:

- Prescribers are reminded to refer to ADA guidelines for the management of patients with diabetes
- Prescribers and pharmacists should make sure when changing or adding medications their patients are aware of the importance of compliance with their medication regimen
- Pharmacists should consult patients taking anti-diabetic drugs (particularly those starting or changing therapy) to be aware of their personal A1C test values and A1C goals

References

1. Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications (DCCT-EDIC) Research Group: Retinopathy and nephropathy in patients with type 1 diabetes four years after a trial of intensive therapy. *N Engl J Med* 342: 381-289, 2000.
2. UK Prospective Diabetes Study (UKPDS) Group: Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). *Lancet* 353: 837-853, 1998.
3. Standards of Medical Care in Diabetes. *Diabetes Care* 29(1), January 2006.

Please refer to pages 36-30 and 36-31 in the DUR Appendix D: Educational Articles section of the Medi-Cal Drug Use Review manual.

Instructions for Manual Replacement Pages — Part 2

July 2006

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Remove and replace:	blood 1 thru 4 blood hcfa 1 thru 5 cal child ser 5/6, 11/12, 15/16 chemo 23/24 hcpcs ii 1/2 medi non hcp 1/2 * medne 7/8 modif used 5/6
Remove:	ophthal 7 thru 18 *
Remove and replace:	path surg 1/2 * rates max lab 7/8 * surg aud 3 tar and non cd4 5/6 tar and non cd8 1/2 * tar and non cd9 1/2 transplant 5 thru 8, 11/12

DRUG USE REVIEW (DUR) MANUAL

Remove from the *Education* section:	36-29
Insert:	36-29 thru 31

* Pages updated due to ongoing provider manual revisions.